

# *HOSPITAL INSURANCE BENEFITS*

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## *A PROGRAMMED LEARNING TEXT*



U.S. DEPARTMENT OF  
HEALTH, EDUCATION, AND WELFARE  
SOCIAL SECURITY ADMINISTRATION

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This booklet is designed to summarize title XVIII of the Social Security Act for the specific purpose of training Social Security Administration employees.

It does not take the place of regulations, operating procedures, or manual instructions.

Bureau of Health Insurance  
Division of Management  
Training Staff

RA  
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## TO THE STUDENT

This is the second in a series of programmed learning texts covering the health insurance program. This text is limited to hospital insurance provisions. Before working through this text you should complete the program on Medicare Enrollment. This text assumes the student has knowledge of certain basic material that is presented in Medicare Enrollment. It is preferred that this text be studied before going on to the third in the series, but this is not mandatory.

This is not an examination, but a programmed learning text. You will get maximum benefit from it by following instructions carefully:

1. When a response is called for, write it in the space provided before checking your answer. This has the effect of forcing you to make a decision, and helps fix the correct answer in your memory.
2. If you choose an incorrect response, reread the frame or frames teaching that concept.
3. Proceed at your own best speed for reading and comprehension. Don't worry about how fast or slow someone else seems to be going.

Most of the pages in the text require the use of an "answer mask," which is provided on the back cover if you do not already have one that is precut. Place the mask on the page so it reveals only the top frame, covering the answers at the right. After you have selected your response, slide the mask down to expose the correct answer and the next frame. Proceed in this manner until you are instructed otherwise.

<p>The Hospital Insurance program provides coverage for inpatient hospital services for 90 days in each benefit period; in addition, a beneficiary has a lifetime reserve of 60 days--each of these days can be used only once during the beneficiary's lifetime. These covered services are subject to a deductible and to coinsurance provisions.</p> <p>Part A provides a maximum of _____ days of hospital services in a benefit period.</p>	<p>150 (90 + 60)</p>
<p>When all or part of the 60 lifetime reserve days are used up, they cannot be renewed, but the basic 90 days of covered services is reinstated whenever a new benefit period begins.</p> <p>If Jack used 20 days of his lifetime reserve in his first benefit period, in his next benefit period he would have a maximum of 90 regular days plus _____ days remaining in the lifetime reserve.</p>	<p>40</p>
<p>We will discuss the definition of "benefit period" later. Now let us turn to the "deductible" and "coinsurance." In each benefit period beginning on or after January 1, 1974, the patient must pay the first \$84 of covered inpatient hospital care charges. This \$84 payment is called the _____.</p>	<p>deductible</p>
<p>The term "coinsurance" as used in the Medicare program refers to the beneficiary's share of the cost of certain services. Ordinarily, coinsurance is involved only in relatively long-term illnesses. The daily coinsurance rate for hospitalization under Medicare from the 61st through the 90th day in a benefit period is \$21. The coinsurance rate for the lifetime reserve days (91st through 150th days) is \$42 per day.</p> <p>(GO ON TO NEXT FRAME)</p>	
<p>Coinsurance has the effect of extending the benefits of the program over a longer period at less cost to the program, by having the beneficiary share the cost (or, "coinsure" himself). The beneficiary knows that his cost for covered services will be limited to an amount that can be financed, or covered by supplementary private insurance. For instance, the maximum coinsurance for the first 90 days of covered services would be \$ _____. (61st - 90th days at \$21 per day.)</p>	<p>\$630</p>

<p>The maximum coinsurance for the additional lifetime reserve of 60 days would be \$_____.</p>	<p>\$2520</p>
<p>With the deductible of \$84 and the \$21 coinsurance amount for the 61st through the 90th day of inpatient care, we have two patient charges to remember.</p> <p>Josephine, who was hospitalized 75 days, would pay a total of \$_____.</p>	<p>\$399</p>
<p>When the hospital stay exceeds 90 days, we must remember a third item, the \$42 coinsurance that applies to lifetime reserve days for benefit periods beginning on or after 1/1/74. After the first 90 days, the coinsurance rate is \$42 a day for the next _____ days.</p>	<p>60</p>
<p>Jack is hospitalized for 112 days in a benefit period. He would pay \$_____. (Do not omit any of the three factors.)</p>	<p>\$1638</p>
<p>The major benefit of the lifetime reserve provision, is to give added protection to beneficiaries with long-term illnesses who are more or less permanently institutionalized and who therefore have, in effect, only one benefit period in their lifetime.</p> <p>But we still have not defined "benefit period" for you, have we? A "benefit period" begins with the first day a beneficiary receives inpatient hospital services or extended care services, and ends after he has not been an outpatient of any hospital or skilled nursing facility for 60 consecutive days.</p>	

<p>The practical problem of determining the ending date of a benefit period gets pretty complicated because of our calendar system. If each month had an equal number of days, it would be easy. So you won't have to count on your fingers every time this question arises, we will teach you how to use the Julian calendar. The Julian calendar assigns a number, 1 through 365, to each day of the year. Of course, on leap year, the last day of the year, December 31, will be numbered _____.</p>	366																
<p>The Julian calendar for regular and leap years is reproduced on the back cover of this book. Tear it off now for easy reference.* Note that the calendar reads down, not across. It works just like a map mileage calculator. You select the column for the month at the top, and the row for the day at the side. The Julian date appears at the point where the month column and date row intersect.</p> <p>Example: (Regular years)                      Julian date</p> <table> <tr> <td>January 15</td><td>15</td></tr> <tr> <td>July 15</td><td>196</td></tr> <tr> <td>October 15</td><td>?</td></tr> </table> <p>*These calendars may be ordered from the GSA catalogue.</p>	January 15	15	July 15	196	October 15	?	288										
January 15	15																
July 15	196																
October 15	?																
<p>How did you do? Try a few more for practice - only this time use the leap year calendar.</p> <table> <tr> <td>February</td><td>18 -</td></tr> <tr> <td>March</td><td>13 -</td></tr> <tr> <td>December</td><td>25 -</td></tr> <tr> <td>July</td><td>4 -</td></tr> </table>	February	18 -	March	13 -	December	25 -	July	4 -	<table> <tr> <td>2/18 -</td><td>049</td></tr> <tr> <td>3/13 -</td><td>073</td></tr> <tr> <td>12/25 -</td><td>360</td></tr> <tr> <td>7/4 -</td><td>186</td></tr> </table>	2/18 -	049	3/13 -	073	12/25 -	360	7/4 -	186
February	18 -																
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<p>Now the trick is to learn when to use the regular and when to use the leap year calendars. Leap year falls in 1964, 1968, 1972, 1976, and every 4 years thereafter. Give the correct Julian dates in these examples:</p> <table> <tr> <td>1. July 4, 1969 -</td><td>185</td></tr> <tr> <td>2. Dec. 25, 1967 -</td><td>359</td></tr> <tr> <td>3. April 1, 1968 -</td><td>092</td></tr> <tr> <td>4. Sept. 5, 1970 -</td><td>248</td></tr> </table>	1. July 4, 1969 -	185	2. Dec. 25, 1967 -	359	3. April 1, 1968 -	092	4. Sept. 5, 1970 -	248									
1. July 4, 1969 -	185																
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3. April 1, 1968 -	092																
4. Sept. 5, 1970 -	248																
<p>To determine when a new benefit period can begin, first convert the date of discharge to a Julian date, then add 60, and reconvert the sum to a regular calendar date.</p> <p>Example: Date of discharge = August 9, 1968</p> <table> <tr> <td>Julian date =</td><td>222 (Remember leap year!)</td></tr> <tr> <td>add</td><td>60</td></tr> <tr> <td></td><td><u>282</u> = October 8, 1968</td></tr> </table> <p>Now you try one - just give the Julian date for the first day in the new benefit period if the date of discharge is March 15, 1969:</p> <p>First day new benefit period could begin is _____ (Julian date)</p>	Julian date =	222 (Remember leap year!)	add	60		<u>282</u> = October 8, 1968	134										
Julian date =	222 (Remember leap year!)																
add	60																
	<u>282</u> = October 8, 1968																

Now, the problem is, converting Julian dates to calendar dates. We did that 1 frame back, without explaining - but of course you can easily see that you must find the Julian date on the chart, and merely read off the month from the top of the column and the day from the end of the row in which the Julian date is located. Let's convert Julian date "134" from the example above:

		MAY			
14		134			14

= May 14, 1969

(GO ON TO THE NEXT FRAME)

Try 3 more conversions - Julian dates to calendar dates. Watch out for those leap years!

- a. Oct. 31, 1972 = ?
- b. April 15, 1969 = ?
- c. June 11, 1970 = ?

- a. 305 (Leap year)
- b. 105
- c. 162

Great! Now you can figure the first day a new benefit period could begin using calendar dates, if we give you a few problems:

Day of Discharge	Last day of Benefit Period
------------------	-------------------------------

- a. August 29, 1969
- b. May 3, 1968
- c. September 17, 1971
- d. January 1, 1972

- a. 301 = 10/28/69
- b. 184 = 7/2/68
- c. 320 = 11/16/71
- d. 061 = 3/1/72

So what do you do if the period extends from one year into the next? It's easy, once you learn it...you do it the same way as usual, but if the sum exceeds 365 (366 in a leap year) you merely subtract 365 or 366 as appropriate, and add 1 to the year. For instance:

Dec. 21, 1968 = 356  
           add     60  
               416               1968  
       Subtract 366           +    1  
               50 = Feb. 19, 1969

You try this one--date of discharge is Nov. 25, 1969. What is the first day the next benefit period could begin?

January 24, 1970

Again, try 3 problems to test your skill:

Date of Discharge	First Day New Benefit Period Could Begin
-------------------	--

- a. Dec. 3, 1972
- b. Nov. 11, 1970
- c. Nov. 5, 1969

- a. Feb. 1, 1973
- b. Jan. 10, 1971
- c. Jan. 4, 1970

The Julian calendar also can be used for figuring the number of days of hospital care that have elapsed. Again, we start by finding the Julian date for the day of discharge. From this, subtract the Julian date for the day of admission. The remainder is the number of days of hospital care.  
 Example: John was admitted to Westside Hospital July 5, 1970. His date of discharge was August 30, 1970.

August 30 = 242

July 5 = 186  
           56 days

As you see, this is a much simpler procedure, since you do not have to reconvert the answer to a Julian date--it is already in the form you need--just the number of days that have elapsed. Try 3 problems in the next frame, then we'll quit this foolishness and go on to more important things:

<u>Date of Admission</u>	<u>Date of Discharge</u>	<u>Elapsed Days</u>
--------------------------	--------------------------	---------------------

a. Feb. 13, 1972	May 1, 1972	
------------------	-------------	--

a. 78 days

b. Dec. 10, 1969	Jan 5, 1970	
(Hint: Add 365 to Julian date for 1/5/70 before subtracting)		

b. 26 days

c. July 31, 1968	Oct 12, 1968	
------------------	--------------	--

c. 73 days

You will not need to use the mask; the next several pages are arranged in "scrambled book" format.

ITEM 1 You have already learned that benefits will be provided for inpatient hospital services for 90 days in each benefit period with the patient paying the first \$84 of inpatient hospital services in a benefit period beginning in 1974. For each day after the 60th day that a patient receives benefits (up to 90 days) he must pay a daily coinsurance of \$21 a day. For each day after the 90th day that a patient receives benefits from his lifetime reserve, he must pay a daily coinsurance of \$42 a day.

A benefit period begins with the first day a beneficiary receives inpatient hospital services or extended care services and ends after he has been out of a hospital or skilled nursing home for 60 consecutive days.

Beneficiary Joan Shause entered Municipal Hospital on July 30, 1974, and was not released until October 10, 1974. Assuming that Joan is not required to enter a hospital or a skilled nursing home during the remaining part of the year, what is her benefit period?

- a. July 30 through December 8 (See Item 2)
- b. July 30 through October 10 (See Item 3)
- c. July 30 through September 27 (See Item 4)

ITEM 2 (1a) Right! Joan's benefit period lasts from July 30, the day she entered the hospital, through December 8, 60 days after her October 10 release date. We begin counting with October 10, (the day of her discharge). Joan's total hospital stay from July 30 to October 10, was a long one-- 72 days to be exact. Once Joan has paid the \$84 deductible and the \$21 daily deductible for 12 days, the HI program will provide benefits to cover the cost of all ordinary inpatient hospital services for her 72-day stay.

Once a benefit period has been started, it will be prolonged by each subsequent admission to any hospital or skilled nursing home that occurs before the end of the benefit period. Thus, a benefit period could be extended almost indefinitely if a patient should be readmitted to a hospital or skilled nursing home repeatedly at less than 60-day intervals. This is true whether or not the institution is participating in the Medicare program. Go on now to Item 5.

ITEM 3 (1b) October 10 is Joan's date of release from Municipal Hospital, but is not the end of her "benefit period." Joan's "benefit period" cannot end until she has been out of the hospital for 60 consecutive days starting with October 10 (date of discharge) as the first day out of the hospital. "Benefit period" is a technical term that refers to the period of time beginning with the first day a patient receives inpatient hospital or extended care services during a month in which he is entitled to benefits, and ends after he has not been an outpatient of any hospital or skilled nursing facility for 60 consecutive days. Now return to Item 1 and select another answer.

ITEM 4 (1c) July 30 through September 27 is the first period of 60 days that Joan spent in the hospital, the period for which she can receive benefits for inpatient hospital services after she has paid the \$84 deductible. This is not her "benefit period," however. A "benefit period" begins with the first day a patient receives inpatient hospital services or extended care services during a month in which he is entitled to benefits, but ends only after he has been out of the hospital or skilled nursing home for 60 consecutive days (starting with the date of discharge). Go back to Item 1 and select another answer.

ITEM 5 The Hospital Insurance program provides benefits for three different kinds of services. First, it gives protection against the cost of reasonable and necessary inpatient hospital services. Thus, the program helps to pay for the reasonable cost of services ordinarily furnished by hospitals to their inpatients. These services include room (semi-private) and board, regular nursing care, drugs for the use of the patient in the hospital, and other medical supplies, appliances and equipment which are a necessary part of the patient's treatment in the hospital. For example, wheelchairs and crutches for the use of the patient in the hospital would belong in this final category.

The Hospital Insurance program does not cover services furnished to the patient for his own convenience, such as private duty nursing, a private room, or a television set. (However, private rooms may be covered where they are medically necessary for the patient's treatment or where no other type of room is available and the beneficiary requires immediate hospitalization.) Also not covered by the Hospital Insurance program are doctors' services except those provided by medical and dental interns and residents participating in an approved teaching program.

Which of the lists below contains only items that could be paid for under the HI program as inpatient hospital services?

- a. Semi-private room and board; drugs; private duty nursing care. (See Item 6)
- b. Drugs; semi-private room and board; surgeons's fee; regular nursing care. (See Item 7)
- c. Semi-private room and board; drugs; regular nursing care. (See Item 8)
- d. Semi-private room and board; regular nursing care; pathologist's fee. (See Item 9)

ITEM 6 (5a) Although semi-private room and board and drugs can be paid for under the Hospital Insurance program, private duty nursing care cannot. The Hospital Insurance program provides benefits to cover only those services ordinarily furnished by hospitals to their inpatients. Hospitals do provide for nursing care for their patients, but special private duty nursing care is considered to be an expense for which the patient is responsible over and above normal hospital expenses.

Please return to Item 5 and choose another answer.

ITEM 7 (5b) You have correctly learned that drugs, semi-private room and board, and regular nursing care can all be provided under the Hospital Insurance program. Remember, however, that the cost of physicians' services would not be covered (except for the services of interns and residents-in-training under approved teaching programs). The Hospital Insurance program provides benefits to cover only those services ordinarily furnished by hospitals to their inpatients. A surgeon usually does his work in a hospital, but as a physician his fees are not covered by the Hospital Insurance program. His services are not among those furnished by the hospital.

Please return to Item 5 and choose another answer

ITEM 8 (5c) Excellent! Semi-private room and board, drugs, and regular nursing care can all be paid for under the Hospital Insurance program as inpatient hospital services. In some cases a private room can be furnished, but only where it is medically necessary for the treatment of the patient. If a beneficiary wanted a private room even though it was not medically necessary, the Hospital Insurance program would pay for the cost of a semi-private room, and the beneficiary would make up the difference himself. Go to Item 10.

ITEM 9 (5d) Regular nursing care and semi-private room and board are two items always furnished to hospital inpatients that are covered by the Hospital Insurance program. A pathologist, however, is a physician, and, since hospital insurance does not cover the cost of physicians' services, his fee could not be covered under the Hospital Insurance program. Remember that hospital insurance provides benefits to cover only those services ordinarily furnished by hospitals to their inpatients. In addition to the two items mentioned above, these include drugs and biologicals and any other ordinary medical supplies that are a necessary part of the patient's treatment in the hospital.

Now return to Item 5 and choose another answer.

ITEM 10 During April, 1974, beneficiary Alice Bolcher entered County Hospital for treatment of a minor stomach ailment. The total covered charges of her 10-day stay and treatment while in the hospital was \$550. This was her only hospitalization during this particular benefit period. What part of the bill will be covered by the Hospital Insurance program?

- a. The entire \$550 (See Item 11)
- b. \$466 (See Item 12)
- c. \$256 (See Item 13)

ITEM 11 (10a) The entire \$550. This is the total charge of Alice's ordinary inpatient hospital services. The amount we are interested in here, however, is the amount of the bill covered by hospital insurance. The patient is responsible for the first \$84 of inpatient hospital charges in each benefit period. The Hospital Insurance program will then pay the reasonable cost of the balance. Now go back to Item 10 and choose another answer.

- ITEM 12 (10b) Right! \$466 will be covered by the Hospital Insurance program. You arrived at this amount by subtracting \$84 from the \$550 total cost of inpatient hospital services. The patient is responsible for the first \$84 of such services and the hospital insurance then covers the balance. Now go on to Item 14.
- ITEM 13 (10c) You are partially correct. You charged Alice for the first \$84 of inpatient services. She is responsible for this amount. However, you have also included \$21 a day for Alice's 10-day stay in the hospital. Remember, the first 60 days are not subject to a daily coinsurance; only for the last 30 days of the 90-day period must the patient pay a daily coinsurance. Now go back to Item 10 and choose another answer.
- ITEM 14 Beneficiary Sam Jones recently required 70 days of care in Mercy Hospital. He stayed in a semi-private room and received no special personal comfort services or conveniences. The charge for the hospital services during the 70-day stay was \$5600. Assuming that this was his only hospitalization during this particular benefit period, what part of the bill will be paid by the Hospital Insurance program?
- a. \$5,516 (See Item 15)
  - b. \$5,306 (See Item 16)
  - c. \$5,390 (See Item 17)

- ITEM 15 (14a) \$5,516 would be correct if Sam has spent only 60 days in the hospital. He would then pay the \$84 deductible and hospital insurance would assume responsibility for the rest. However, Sam spent 70 days in Mercy Hospital. Remember, for the last 30 days of the 90-day period for each benefit period, the patient must pay a daily coinsurance of \$21. Sam is responsible for this deductible for the last 10 days of his 70-day stay. Go back to Item 14 and choose another answer.
- ITEM 16 (14b) Very good! You remembered to apply several important rules to arrive at the correct figure covered by the Hospital Insurance program. \$5,600 was the total charge for the ordinary services furnished by the Mercy Hospital. Of this amount, Sam pays the \$84 deductible which is applied to each benefit period; and since he spent over 60 days in the hospital, he must pay \$21 a day for each day over the 60th day. (10 days - \$210) He will be covered for 90 days in this benefit period before having to use any of his lifetime reserve days. After 90 days, Sam is responsible for a \$42 daily coinsurance cost up to the 150th day, assuming he has not previously used any of his lifetime reserve days. Beginning with the 151st day, Sam is responsible for all hospital charges. Go on to Item 18.
- ITEM 17 (14c) You are partly correct. You remembered that the patient must pay a \$21 daily coinsurance for the 61st to 90th day of hospitalization during a benefit period. However, you forgot that he is also responsible for a \$84 deductible for each benefit period. Please return to Item 14 and choose another answer.

ITEM 18 Here's another problem involving "benefit period."

Jim Keene, a nondisabled beneficiary, was born on 9/5/03. On August 1968, Jim entered the hospital. After he had been in the hospital for two weeks, Jim's doctor decided he was probably ready to go home; and he was discharged on September 12.

However, Jim had only been home for three days before he began to have a slight relapse. On his doctor's orders, Jim entered a skilled nursing home for continued rest and care on September 15. Slowly, his condition improved enough so that on October 27, he was able to return home.

Assuming that he remains home for the rest of the year, which of the following are inclusive dates for Jim's benefit period?

- a. 8/29 through 12/25 (See Item 19)
- b. 9/1 through 12/23 (See Item 20)
- c. 9/1 through 12/25 (See Item 21)
- d. 9/4 through 11/10 (See Item 22)
- e. 9/4 through 12/25 (See Item 23)

ITEM 19 (18a) Your answer is "8/29 through 12/25." You have correctly determined that Jim's benefit period will end with 12/25, 60 consecutive days after his discharge from the skilled nursing facility (counting October 27 as his first day out of the skilled nursing facility), but it does not begin with 8/29. Even though 8/29 is the first day Jim received inpatient hospital services, it did not occur during a month in which he was entitled to HI benefits. Except for disabled beneficiaries, an individual cannot be entitled to benefits under the basic plan until the month he is 65 years old. Return to Item 18 and choose another answer.

ITEM 20 (18b) "9/1 through 12/23" is partly correct. Jim's benefit period begins with 9/1 because this is the first day he received inpatient hospital services during a month in which he was entitled to benefits. However, 12/23 is not the last day of the benefit period. In counting the 60-day period Jim was out of a hospital or skilled nursing facility, you have probably included the two full days between the hospital and skilled nursing facility stay, plus 58 days following the skilled nursing facility discharge. Although this is a 60-day period during which Jim was not in a hospital or skilled nursing facility, his benefit period does not end until he has been out for 60 consecutive days starting with the day of discharge. Return to Item 18 and choose another answer.

ITEM 21 (18c) Correct! Jim's benefit period extends from 9/1 through 12/25. These are inclusive dates, so a new benefit period could not begin before 12/26. 9/1 is the first day Jim received inpatient hospital services during a month in which he was entitled to benefits. Jim's benefit period did not begin during August because he could not become entitled to HI benefits until the month he attained age 65. 12/25 is the last day of his benefit period because it is the 60th consecutive day after his October 27 discharge from the skilled nursing facility, counting October 27 as Jim's first day out of the skilled nursing facility. Now go on to Item 24.

ITEM 22 (18d) You are probably a little confused here. Although 9/4 is the day Jim attains age 65, which is one of the requirements for entitlement to benefits under the Hospital Insurance program for nondisabled beneficiaries, it is not the first day of his benefit period. Jim's benefit period begins with the first day he receives inpatient services during a month in which he is entitled to hospital insurance benefits. Jim has been receiving these services since 8/29. Furthermore, the benefit period ends only after Jim has been out of the hospital or skilled nursing facility for 60 consecutive days. September 15 he entered a skilled nursing facility. Hence, he has not been out of the hospital or skilled nursing facility for 60 consecutive days. Go back to Item 18 and choose another answer.

ITEM 23 (18e) Your answer is "9/4 through 12/25." You have correctly determined that Jim's benefit period will end with 12/25, 60 consecutive days after his October 27 discharge from the skilled nursing facility (counting October 27 as the first day out of the skilled nursing facility), but it does not begin with 9/4. Although 9/4 is the day Jim attains age 65, which is one of the requirements for entitlement to benefits under the Hospital Insurance program for nondisabled beneficiaries, it is not the first day of his benefit period. Jim's benefit period begins with the first day he receives inpatient services during a month in which he is entitled to hospital insurance benefits. Jim has been receiving these services since 8/29. Go back to Item 18 and choose another answer.

ITEM 24 Tom Fenton was hospitalized on April 2, 1974. By April 17, his doctor thought that he was well enough to return home, and he was released, but on June 5 he was back in the hospital. This time Tom remained until September 18. Below is a chronological list of Tom's treatment and the cost of the services he received. He has never used any of his lifetime reserve days.

(April 2 begins a "benefit period")

<u>Date</u>	<u>Item</u>	<u>Cost</u>
April 1	Doctor visits Tom's home	\$10
April 2	Tom enters hospital	
▲	semi-private room & board, nursing.....	\$80/day
(15 days*)	drugs prescribed by doctor.....	\$20 (total)
▼		
April 17	Tom is discharged from hospital	
June 5	Tom reenters hospital	
▲	semi-private room and board, nursing.....	\$80/day
(104 days)	pathologist's fee (June 20) .....	\$200 (total)
	laboratory tests (July 4) drugs prescribed by doctor (after September 1).....	\$20 (total) \$75 (total)
▼		

September 17 Tom is discharged from hospital

Calculate the amount of benefits that will be paid under the Hospital Insurance program for these services:

- 7,903 (See Item 25)
- 7,703 (See Item 26)
- 9,551 (See Item 27)
- 8,249 (See Item 28)

\*In counting the number of days of hospitalization, include the day a patient is admitted to the hospital, but do not count the day of discharge.

ITEM 25 (24a) You are partly correct. You correctly calculated the amount of benefits that will be paid, but you included an extra service. The \$200 pathologist's fee is not paid for by the Hospital Insurance program. The only physician's services covered are those furnished by medical and dental interns and residents participating in an approved training program. Please return to Item 24 and choose another answer.

ITEM 26 (24b) Very good! You have learned a number of important rules for computing benefits under the Hospital Insurance program. First, because Tom did not remain out of the hospital for 60 consecutive days, both periods of hospitalization came within the same benefit period. Therefore, the \$84 deductible is applied only once. You also remembered that the patient must pay \$21 a day for the last 30 days of the 90-day period for each benefit period, and \$42 a day for days in the lifetime reserve period. Only the first 60 days are covered completely by hospital insurance (after the \$84 deductible has been paid). The charges for covered services for Tom's illness are as follows:

119 days of semi-private room and board at \$80/day.....	\$9520
Drugs for use in hospital.....	95
Laboratory tests.....	20
	<hr/>
	\$9635

Since Tom was in the hospital for a total of 119 days, he must pay a part of the charges (coinsurance) for covered services after the first 60 days. The Hospital Insurance program covers him for the first 60 days but he must pay \$21 a day for the last 30 days of the 90-day period. After the first 90 days, he uses days in his lifetime reserve, with coinsurance of \$42 per day. He must also pay the \$84 deductible amount which is applied toward the first 60 days. So, he will pay a total of \$1932 (30 extra days at \$21/day, 29 lifetime reserve days at \$42 per day, plus the \$84 deductible). The Hospital Insurance program will cover \$7703 of the total. Go on to Item 29.

ITEM 27 (24c) Just a minute! You have forgotten one important factor. A patient is covered under the Hospital Insurance program for 90 days in each benefit period. He pays a \$84 deductible and hospital insurance pays for all covered services for the first 60 days. However, for the next 30 days of the 90-day period that a patient spends in the hospital during the same benefit period, he must pay \$21 for each of these days and for the 91st through 150th day he must pay \$42 per day coinsurance. Now go back to Item 24 and select another answer.

ITEM 28 (24d) You correctly calculated the amount of covered charges, but you must have forgotten the "benefit period" rule. A "benefit period" begins with the first day a patient receives inpatient services from a qualified hospital or skilled nursing facility and ends when he has not been an inpatient of any hospital or skilled nursing facility for 60 consecutive days, beginning with the date of discharge. Tom was out of the hospital for only 50 days before he reentered, so his cost of services from April 2 to April 17 and June 5 to September 17 are considered to be in the same benefit period. Now return to Item 24 and select another answer.

ITEM 29 Here is a similar set of data for the hospital costs incurred by beneficiary James Bogdan. All dates are for the year 1974. Assume that March 3 begins a benefit period, and that none of the lifetime reserve days have been used.

<u>Date</u>	<u>Item</u>	<u>Cost</u>
March 3	Mr. Bogdan enters hospital	
↑	private room & board,	
	nursing.....	\$90/day
(17 days)	drugs prescribed by doctor	
	.....	\$40 (total)
↓	physician's charges.....	\$50 (total)
March 20	Mr. Bogdan discharged	
June 6	Mr. Bogdan reenters the same hospital	
↑	semi-private room and board,	
	nursing.....	\$80/day
(58 days)	drugs and biologicals (through July 18).....	\$140 (total)
	drugs and biologicals (July 19-August 3).....	\$100 (total)
↓	Operating room fee (June 9)....	\$ 50 (total)
August 3	Mr. Bogdan discharged	

Select the total amount of benefits that will be paid under the Hospital Insurance program for these services:

- a. \$6332 (See Item 30)
- b. \$6212 (See Item 31)
- c. \$6162 (See Item 32)
- d. \$6246 (See Item 33)

ITEM 30 (29a) You are partially correct, but you have forgotten one important provision of the program. Only those services that are medically necessary for the treatment of the patient are covered. A private room, unless it is necessary for the treatment of the patient, is not covered. The semi-private rate will be paid and the patient must pay the difference. Now return to Item 29 and choose another answer.

ITEM 31 (29b) You have included the \$50 physician's charges in the first benefit period. The Hospital Insurance program will not pay for any physicians' services. Only those services furnished by medical and dental interns and residents participating in a hospital training program are covered. Now return to Item 29 and choose another answer.

ITEM 32 (29c) Excellent! You correctly perceived that Mr. Bogdan was in the hospital for two separate "benefit periods." Therefore, the \$84 deductible is applied twice (to the first 60 days of each benefit period). You also remembered that the physician's charge in the first benefit period would not be covered. You also correctly determined that the cost of Mr. Bogdan's private room in the first benefit period is not covered. Hospital insurance will pay the cost of semi-private accommodations (\$80/day) and Mr. Bogdan must pay the difference.

March 3 - March 20

17 days room and board at \$80/day.....	\$1360
Drugs.....	40
Total.....	<u>\$1400</u>
Less \$84 deductible.....	<u>\$1316</u>

June 6 - August 3

58 days room and board at \$80 day.....	\$4640
Drugs and biologicals (\$140 plus \$100).....	240
Operating room fee.....	50
Total.....	<u>\$4930</u>
Less \$84 deductible.....	<u>\$4846</u>
	\$6162

Remember that the first 60 days of inpatient hospital services are covered completely by the plan after the \$84 deductible has been paid. For the last 30 days of the 90-day limit, the patient pays coinsurance equal to 1/4 of the inpatient hospital deductible (\$21/day at present). The coinsurance is \$42 per day for the 60 days in the additional lifetime reserve. Since Mr. Bogdan did not exceed 60 days in either spell of illness, he only pays the \$84 deductible for each spell of illness. Go on to Item 34.

ITEM 33 (29d) Time out! You have forgotten the "benefit period" rule. A "benefit period" begins with the first day a patient receives inpatient services from a qualified hospital or skilled nursing facility and ends after he has not been an inpatient of any hospital or skilled nursing facility for 60 consecutive days. Mr. Bogdan was out of the hospital for over 70 days before he reentered in June, therefore, the \$84 deductible is applied a second time. Now go back to Item 29 and choose another answer.

ITEM 34 An individual cannot receive benefits for services at just any institution that calls itself a hospital or skilled nursing facility. Generally benefits will be paid for inpatient services only at a participating hospital or skilled nursing facility. These must meet certain requirements pertaining to its purpose, organization, and operations. Now we'll turn to other benefits provided under the Hospital Insurance program. Go on to Item 35.

ITEM 35 Besides inpatient hospital services, hospital insurance also provides for posthospital extended care services. These benefits help pay for the cost of care in a skilled nursing facility such as a skilled nursing home or a convalescent home; however, only "posthospital" care is covered. The patient must have first been hospitalized for 3 or more consecutive days and then transferred to the facility for continued care of the same illness within 14 days of his hospital discharge except under certain conditions, when a 28 day period is permitted. The intent of this provision is to permit patients able to move from the high-cost hospital bed to do so, so the bed space may be used more appropriately by the acutely ill.

Beneficiary Jennifer Smith recently spent three weeks in City Hospital; her entire stay was medically necessary. Since Jennifer had used up all her available hospital days in a previous benefit period, the cost of her stay was not covered under hospital insurance. After her stay in the hospital, Jennifer was transferred directly to Golden Age Nursing Home, a participating skilled nursing facility, for continued care of the illness for which she had been hospitalized. Based on what you have learned so far, could Jennifer expect the cost of her nursing home care to be paid by the Hospital Insurance program?

- a. Yes (See Item 36)
- b. No. Jennifer's three-week hospital stay does not qualify her for extended care benefits because she did not stay in a participating hospital. (See Item 37)
- c. More information is needed. (See Item 38)

ITEM 36 (35a) Yes, she certainly could expect to get some help. Jennifer was transferred to the participating skilled nursing facility immediately after her hospital discharge, which is within the 14-day requirement, of course. Furthermore, she was hospitalized for three weeks, while the minimum requirement is only three days. The fact that the hospital was not participating does not affect her eligibility to receive benefits for post-hospital extended care.

We have said that an individual can qualify for post-hospital extended care following a qualifying stay in a hospital. This rule is a generalization that will hold true in most cases.

Finally, a patient who has been discharged from a skilled nursing facility at which he was receiving benefits can again receive extended care benefits in the same benefit period (without reentering a hospital) if he is readmitted to any participating skilled nursing facility within 14 days of his discharge. Now go on to Item 39.

ITEM 37 (35b) You have decided that Jennifer's three-week hospital stay does not qualify her for extended care benefits because she had not received covered inpatient services during her hospitalization. Based on what you should have learned so far, this answer is not correct. We have said that an individual can qualify for post-hospital extended care following a three-day stay in any hospital. Thus, he is not penalized when he transfers from a nonparticipating hospital. Now return to Item 35 and choose another answer.

ITEM 38 (35c) You believe that more information is needed. This answer is not correct. So far you have learned only two qualification requirements for posthospital extended care. The patient must have (1) had a qualified hospital stay of at least 3 consecutive days, and then (2) transferred to the facility for continued care of the same illness generally within 14 days of his hospital discharge. You have been given enough information to decide whether or not Jennifer meets these requirements. Please return to Item 35 and choose another answer.

ITEM 39 Payments can be made for up to 100 days of care in the skilled nursing facility in a benefit period. After 20 days, the patient must pay a daily coinsurance equal to  $1/8$  of the inpatient hospital deductible. For benefit periods beginning 1/74 this is \$10.50 per day. Thus complete payment will be made for the first 20 days; for the last 80 days the patient will pay a coinsurance of \$10.50 per day.

Ben E. Fisher recently spent 30 days in a participating hospital and received covered inpatient services during his stay. He was then transferred to a skilled nursing facility. Mr. Fisher remained in the skilled nursing facility for 30 days and received a covered level of care for all days. How much must Mr. Fisher pay as his share of the payment for the services received in the skilled nursing facility?

- a. \$105 (See Item 40)
- b. \$315 (See Item 41)
- c. None (See Item 42)

ITEM 40 (39a) Right again! Mr. Fisher qualified for coverage since he was an inpatient in a hospital for at least 3 days and upon discharge was transferred immediately to the skilled nursing facility. You remembered that 20 days of posthospital extended care services are paid for by Medicare and that for any days in excess of the first 20, the patient pays a daily coinsurance equal to  $\frac{1}{8}$  of the inpatient hospital deductible (or \$10.50 per day). So Mr. Fisher pays for 10 days at \$10.50 per day \$105. Go on to Item 43.

ITEM 41 (39b) The first 20 days of posthospital benefits in a skilled nursing facility are paid for by Hospital Insurance. Only after 20 days must the patient pay a daily coinsurance equal to  $\frac{1}{8}$  of the inpatient hospital deductible. You have charged Mr. Fisher \$10.50 per day for his full 30-day stay. Now go back to Item 39 and choose another answer.

ITEM 42 (39c) None? Do not be so generous! The Hospital Insurance program will pay for services which Mr. Fisher receives for the first 20 days. But after 20 days he must pay a daily coinsurance of \$10.50 per day. So Mr. Fisher must pay a coinsurance for the last 10 days of his 30-day stay. Please return to Item 39 and choose another answer.

- ITEM 43 Beneficiary Mrs. Louise Johnson was first hospitalized on March 14, 1974, and was released 40 days later. She received covered inpatient hospital services for the 40-day stay. Then, after spending a week at home, Mrs. Johnson was put in a skilled nursing facility by her doctor. She spent 30 days in the skilled nursing facility and the total charge for covered services during the 30-day stay was \$500. How much of this amount will be covered by the Health Insurance program and how much will Mrs. Johnson pay?
- a. HI program - \$311                      Mrs. Johnson - \$189 (See Item 44)
  - b. HI program - \$500                      Mrs. Johnson - None (See Item 45)
  - c. HI program - \$395                      Mrs. Johnson - \$105 - (See Item 46)

ITEM 44 (43a) You correctly figured that Mrs. Johnson will pay \$10.50 per day for the last 10 days of her stay. Only the first 20 days are covered completely by HI. However, you have also incorrectly included a \$84 deductible that Mrs. Johnson must pay. The only deductible applied to posthospital skilled nursing services is the \$10.50 daily coinsurance applied to any days over 20 that the patient remains in the facility (up to 100 days). Now go back to Item 43 and choose another answer.

ITEM 45 (43b) Just a minute! You say that HI will pay the entire \$500 for covered services. Remember, for any days over the first 20 that a patient spends in a skilled nursing facility, he must pay a daily coinsurance of \$10.50 (1/8 of the inpatient hospital deductible). Louise was in the nursing facility for 30 days; she must pay a coinsurance for the last 10 days. Now go back to Item 43 and choose another answer.

ITEM 46 (43c) Excellent! You understand the method of payment for covered services in a skilled nursing facility. Mrs. Johnson was hospitalized for more than the 3-day minimum requirement and was transferred to the skilled nursing facility within 14 days of her discharge from the hospital. So she qualified for benefits and HI paid for the first 20 days. For the last 10 days of her 30-day stay, Mrs. Johnson paid a daily coinsurance of \$10.50 (1/8 of the inpatient hospital deductible). Now go on to Item 47.

ITEM 47 The posthospital extended care provision would cover the items and services generally furnished by skilled nursing facilities. These include room and board in two-to-four-bed (semi-private) accommodations, nursing care, physical, occupational and speech therapy, and such drugs as are ordinarily furnished by the facility to its patients. However, in no case could payment be made for any service, drug or other item which could not be paid for under the Hospital Insurance program if furnished in a hospital.

Additionally, payment could be made for the medical services of interns and residents in training and other diagnostic and therapeutic services furnished inpatients of the skilled nursing facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records.

Which of the following statements is true?

- a. Posthospital extended care services for which benefits would be paid are those generally furnished by skilled nursing facilities, such as room and board in semi-private accommodations, nursing care, and rehabilitative therapy, and including some items for which payment could not be made under the Health Insurance program if furnished in a hospital. (See Item 48)
- b. Under the extended care provision, benefits would be paid for services that are generally furnished by skilled nursing facilities, and in some cases, services furnished by hospitals to inpatients of skilled nursing facilities. (See Item 49)

ITEM 48 (47a) Not so fast now. Although it is true that benefits are only paid for posthospital service generally furnished by skilled nursing facilities, payment can never be made for any service or item which could not be paid for under the Hospital Insurance program if furnished in a hospital. Please return to Item 47 and choose another answer.

ITEM 49 (47b) Very good! Benefits under this provision are paid for services generally furnished by skilled nursing facilities. These include room and board in semi-private accommodations, nursing care, and rehabilitative therapy. In addition, payment could be made for services furnished inpatients of the skilled nursing facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records (e.g., medical services provided by an intern or resident-in-training of a hospital, diagnostic, or therapeutic services provided by a hospital). Payment could not be made, however, for any service, drug, or other item which could not be paid for under the Hospital Insurance program if furnished in a hospital. Now go on to Item 50.

ITEM 50 Many skilled nursing facilities provide long-term custodial care in addition to the full-time nursing and service for patients just discharged from a hospital. The HI program was not intended to pay any of the costs of custodial care. There is sometimes a fine line between skilled nursing services and custodial care, but there is a difference. The law requires the attending physician to certify that the patient needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which he received inpatient services, which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. The doctor must make this certification when the patient is admitted, with recertification required within 14 days and again no later than every 30 days following the first recertification.

Basically, coverage is provided where the patient's condition requires, on a daily basis, skilled nursing care by or under the supervision of a licensed or skilled nurse. If the services required are merely assistance in daily maintenance such as bathing, dressing, going to the bathroom, taking medicine that could normally be self-administered, etc., they are not considered skilled nursing services.

Granny Erfledorf was admitted to the Southside SNF immediately after discharge from a 5-day stay in the Southside Hospital. She had a broken arm that is now in a cast. She is scheduled to stay in the SNF for 8 weeks. She cannot go home because she lives by herself and needs help bathing, dressing and going to the bathroom. In addition, she must take a teaspoon of special vitamin syrup three times a day and she cannot do this herself because of her broken arm. As a matter of fact, someone has to feed her. The doctor expects she will be able to feed herself in four or five weeks if she does the exercises he has prescribed.

- a. Granny will have her SNF bill paid in full for the entire 8 weeks, since the doctor had her put in the facility. (See Item 51)
- b. None of the SNF services will be paid by Part A, since the services required are primarily custodial in nature. (See Item 52)
- c. Mrs. Erfledorf will have the SNF care covered for the first 4 or 5 weeks, until she can feed herself and get her own medicine. (See Item 53)

- ITEM 51 (50a) That would be nice, but you made the wrong choice here. Most people we know who have had broken arms are able to care for most of their own needs once they are in a cast and out of the hospital. Sometimes they need the help of the family for a while, and the fact that Granny has no family does not change the medical picture. For instance, a completely senile person requiring a nurse to administer medications, take care of all daily needs, etc., is in a custodial situation, generally, and would not qualify for covered SNF care unless some other medical reason exists to justify payment. Go back to Item 50 and select another answer.
- ITEM 52 (50b) Three cheers! You correctly recognized that all the conditions we mentioned were primarily custodial. The bathing, feeding and vitamin giving requirements all could be met by non-medical people. We sympathize with Granny's distress over having to pay for the entire SNF bill, but our sympathy cannot pay her bill. Go to Item 54.
- ITEM 53 (50c) Please, now, you do not really mean it, do you? Sure, Mrs. Erfledorf needs someone to give her the spoonful of vitamins and to feed her - but you could do that, and chances are, you are not a licensed nurse. In fairness, we must congratulate you for realizing that the services Granny required because of her broken arm were simply custodial care. Now that you realize the services she received in the first 4-5 weeks were also custodial in nature, return to Item 50 and select the correct answer.

ITEM 54 So far we have learned that the HI program provides benefits for inpatient hospital services and posthospital extended care. The third kind of benefits provided are for posthospital home health services. Payments would be made for up to 100 visits by home health personnel during the one-year period following the patient's latest discharge from a hospital or skilled nursing facility unless it is terminated earlier by the beginning of a new benefit period. To be eligible for home health benefits, the beneficiary would have to have been an inpatient in a hospital for a medically necessary condition for at least 3 days or have had a covered stay in a skilled nursing facility, and a home health plan for his care must be developed by a physician and reduced to writing within 14 days after his discharge.

Beneficiary Ivan Tucker spent one week in a hospital but received no benefits under the HI program for inpatient hospital services because he had utilized all available benefit days in a previous stay. He was discharged on April 12, 1973. By April 21, Ivan's doctor had established a home health care plan for him. Which of the following statements is true?

- a. All benefits payable to Ivan for home health services under the HI program are limited to the one-year period following his discharge from the hospital. (See Item 55)
- b. Benefits can be paid under the HI program for the first 100 visits of home health personnel following Ivan's discharge from the hospital. (See Item 56)
- c. Ivan cannot receive benefits for services under the HI program because he had not qualified for benefits during his stay in the hospital. (See Item 57)

ITEM 55 (54a) You are absolutely correct. Benefits payable under the posthospital home health care provision are limited to a maximum of 100 visits by home health services personnel during the one year period following the patient's discharge from a qualifying stay in a hospital or skilled nursing facility. Ivan qualified for these benefits because he had been hospitalized for at least 3 days and the plan was established within 14 days of his discharge from the hospital. A beneficiary can qualify for home health benefits on the basis of a 3-day hospital stay without having received inpatient hospital benefits, but he cannot qualify on the basis of a stay in a skilled nursing facility unless it was a covered stay. Go on to Item 58.

ITEM 56 (54b) Benefits can be paid for the first 100 visits of home health personnel, but only during the first year after a patient's latest discharge from a hospital or skilled nursing facility. Thus, the statement you chose would have been true only if the one-year limitation had been included. As it stands, unqualified, the statement is false. Now return to Item 54 and choose another answer.

ITEM 57 (54c) The three-day stay requirement applies only to prior hospitalization, not to length of stay in a skilled nursing facility. If a beneficiary is to qualify for home health care benefits following a stay in a skilled nursing facility the only requirement is that the stay was a covered one. Now return to Item 54 to choose another answer.

ITEM 58 Sylvia Himmelfarb had been receiving inpatient hospital services benefits before her recent transfer to a skilled nursing facility, where she also received benefits under the Health Insurance program. After spending only two days in the skilled nursing facility, Sylvia decided to return to her own home. She was unhappy at the skilled nursing facility and thought she could get along well enough on her own. Providing that her doctor establishes a home health care plan within 14 days of her discharge from the skilled nursing facility, can Sylvia receive benefits for these services?

- a. Yes. Sylvia would qualify because the plan was established within 14 days of her discharge from a covered stay in a skilled nursing facility. (See Item 59)
- b. No. Sylvia would not qualify because, although her stay in the skilled nursing facility was a covered one, she had not remained a patient there for the minimum 3-day requirement. (See Item 60)

ITEM 59 (58a) Right you are! Sylvia would qualify because the plan was established within 14 days of her discharge from a covered stay in a skilled nursing facility. The requirement for a three-day stay applies only to hospitals. When the home health services plan is established following a patient's stay in a skilled nursing facility, the only requirement is that the stay in the skilled nursing facility have been a covered one, i.e., the plan must be set up following a covered stay in a participating skilled nursing facility. Go on to Item 61.

ITEM 60 (58b) You say no? Remember, the three-day requirement applies to inpatient hospital services. A person must stay in a hospital for at least 3 days or have had a covered stay of any duration in a skilled nursing facility to be eligible for benefits for home health services. Thus, there is no minimum skilled nursing facility stay requirement for home health benefits. Now return to Item 58 and choose another answer.

ITEM 61 Home health services are services furnished in a patient's home on a visiting basis by a home health agency. These services, which must be furnished under a plan established and supervised by a physician, include part-time nursing care, physical, speech, or occupational therapy, medical social services, and part-time home health aide services. The patient may also receive home health care benefits for services received on an outpatient basis at a hospital, skilled nursing facility, or rehabilitation center, if it is not practical for him to receive the services at home, and the home health agency arranges for such services. The patient's transportation costs incurred traveling to a hospital outpatient department, skilled nursing facility, or rehabilitation center, would not be covered.

Excluded from coverage under this provision are drugs and biologicals, physician's care, the cost of nonhealth related items, such as "meals-on wheels" programs and maid service, and any item or service which would not be covered if furnished to an inpatient of a hospital.

Home health agencies, like hospitals and skilled nursing facilities, must meet certain requirements in order to participate in the Health Insurance program. Go on to Item 62.

ITEM 62 If a beneficiary was in a participating psychiatric hospital on the first day of entitlement to hospital insurance, then there is a special provision to reduce the number of days in his first benefit period. (This "reduction in days" provision relates only to the effect of hospitalization for treatment or diagnosis of mental illness in a psychiatric hospital in the 150 days before first entitlement to hospital insurance benefits.) Each day he was in a psychiatric hospital in the 150 days before first entitlement will reduce by one day the number of days of hospitalization he can get in a psychiatric hospital, or in a general hospital where he gets psychiatric treatment, in his first benefit period.

Confused? Okay, let's take it step by step:

1. Count the number of days he was in a psychiatric hospital in the 150 days prior to hospital insurance entitlement.
2. Subtract this number from 150.
3. This will give the number of days of psychiatric hospitalization he can get in his first benefit period.

When George Evans became entitled to HI benefits, he was in a psychiatric hospital and had been there during 60 of the preceding 150 days. He can get only 90 more days of covered psychiatric hospitalization in his first benefit period. Thereafter, the 60 days he lost due to the "reduction in days" provision could still be used, only if he had any hospitalization for other than mental or emotional illness in this benefit period. For example, if he should fall and break his hip, up to 60 days of covered services in a general hospital would be available to him (assuming he had used up the 90 days of care in psychiatric hospitals in the same benefit period). Of course, the regular coinsurance provisions would apply.

Charlotte has been in a participating mental hospital, since her husband died 3 years ago. She is eligible for HI benefits in August of this year. Her condition has not responded to therapy.

- a. Now that she is 65, HI will pay for 150 days of psychiatric care, since she still needs active therapy and is not a custodial care patient. (See Item 63)
- b. Her care in this hospital can be covered for 90 days, but the reduction in days provision eliminates the additional lifetime reserve days completely. (See Item 64)
- c. She can receive no benefits for the care she receives on account of her mental illness because the reduction in days provision applies. (See Item 65)

ITEM 63 (62a) You have a generous heart, but we cannot go along with you. The law states that we must deduct any days of care in a psychiatric institution prior to the first month of HIB entitlement. It is true that this provision is intended to prevent draining the trust funds to pay for custodial care, but we are not required to make a decision as to whether inpatient psychiatric care is custodial or not. All we need to know is when the patient attained eligibility, and how many days he was in a psychiatric hospital before the month of attainment. Return to Item 62 and choose another answer.

ITEM 64 (62b) Where did you get this idea? We did not say anything about losing only the lifetime reserve days - the reduction in days provision applies to all available days of HI coverage for hospitalization in a psychiatric institution for treatment or diagnosis of mental illness. Return to Item 62 and choose another answer.

ITEM 65 (62c) Absolutely correct! Charlotte may receive no Medicare payments for psychiatric hospital care after she became eligible because she was in the hospital far in excess of 150 days.

However, if Charlotte later requires hospitalization for a condition other than mental illness, the regular 90-day and 60-day additional lifetime reserve provisions apply. Go on to Item 66.

ITEM 66 You have solved a problem exemplifying what happens when a mental patient has been in a psychiatric hospital for 150 days or more prior to entitlement to HI benefits. It is simple to understand since he loses all coverage under Medicare for similar treatment in that benefit period. However, the case where the patient has had less than 150 days in a psychiatric hospital is not so simple.

(Continued on next page)

Let us consider a beneficiary who has been hospitalized in a participating psychiatric hospital for 40 of the 150 days just prior to his first day of entitlement to Part A, Hospital Insurance, and is still a patient in that hospital on the day his entitlement begins. He would still have some Medicare benefits available for his continued stay in that institution. (Remember, we said, "Each day in a psychiatric hospital in the 150 days before entitlement will reduce by one day the number of days of hospitalization he can get in a psychiatric hospital in his first benefit period."). Just subtract the number of days he was in the institution prior to the first day of entitlement; in this case,  $150 - 40 = 110$ . The beneficiary would have his entire 90 day period left, plus 20 days of his lifetime reserve. Thus, he could receive 110 days of covered services in a psychiatric hospital, 60 days fully covered (less the \$84 deductible), 30 days with \$21 per day coinsurance, and 20 days with \$42 per day coinsurance. Just as in the previous example, the 40 days lost because of the reduction in days provision for psychiatric hospital are still available in the same benefit period if the beneficiary after his 110 days in the psychiatric hospital goes into a general hospital for treatment of a condition other than mental illness. These 40 days would then have to be drawn from his lifetime reserve days, with \$42 daily coinsurance to be paid by the beneficiary.

Horst Sellers was confined to a psychiatric institution for diagnosis of a mental condition 55 days before his first entitlement to HI, and his treatment continued for an additional 65 days before he was released. Within 2 weeks of his discharge, he was severely burned in an auto accident, and spent 55 days in the County Hospital for intensive treatment. Select the statement below that gives the correct number of days of covered services available to him. The breakdown of coinsurance requirements is important to the correct answer:

- a. Horst would receive 60 days of psychiatric treatment fully covered by HI, plus 5 days with a \$21 per day coinsurance. Of course, the regular \$84 deductible would apply. In the County Hospital, his first 25 days would be subject to the \$21 coinsurance, since he is in the same benefit period. The remaining 30 days must come from the lifetime reserve, with \$42 a day coinsurance. (See Item 67)
- b. Mr. Sellers would be covered for all his psychiatric treatment after attainment. The first 5 days would be fully covered, subject to the \$84 deductible. The

next 30 days would be subject to the \$21 coinsurance per day and the remaining 30 days would come from the lifetime reserve. In the General Hospital, he would get 55 days full coverage. Since he has 30 days of his lifetime reserve remaining, the cost of the last 10 days of treatment in the County Hospital will be covered subject to the \$42 coinsurance. (See Item 68)

- c. Horst would receive 60 days of the **psychiatric** treatment fully covered by HI, plus 5 days with \$21 per day coinsurance. Of course, the regular \$84 deductible would apply. In the County Hospital, his first 25 days would be fully covered less the \$84 deductible. The remaining 10 days would cost him \$21 per day coinsurance, since this is in a different benefit period and a new 90-day period applies. (See Item 69)

ITEM 67 (66a) You have a good head on your shoulders! This is really a difficult problem, but you successfully followed the example given in the narrative and applied the deductibles in all the right places. It is unlikely that you will be confronted by too many claims or inquiries concerning this reduction in days provision, but now that you have figured out how it works, you should have only one problem left to solve-that is "how can I communicate this to someone else?" We have tried to communicate it by using a couple of examples. Perhaps you can think of a better way. Go on now to a new subject in Item 70.

ITEM 68 (66b) Apparently you either overlooked the hint we gave you in the paragraph preceding the problem, or we did not present it clearly enough. We will assume it was our fault-this is a very difficult concept to explain. Can we put it more plainly? If some days are lost because of the reduction in days provision, they are lost from the end of the 150 day period--not from the beginning of the 90 days of full coverage. This means that the hospital days available for non-mental illnesses start where the others left off, whether it be in the lifetime reserve, the \$21 coinsurance period, or in the first 60 days, up to the number that were affected by the reduction in days.

Example: George lost 15 days due to the reduction in days provision, and remained in the psychiatric hospital 6 months before he was transferred to a general hospital for 3 weeks intensive care to treat a peritonitis condition. He used 60 days of full coverage (less that \$84 deductible), plus all his coinsurance coverage, including 45 days of the lifetime reserve during the 6 months in the psychiatric hospital. He still had 15 days of the lifetime reserve to apply towards the 3-week stay in the general hospital. Now return to Item 66 and select another answer.

ITEM 69 (66c) Did you ever fall into a trap? Not only that, but the trap even looked like a boobytrap!

You correctly identified the conditions applying to the continued treatment on the psychiatric hospital, but you blew it completely when you fell for that additional \$84 deductible and new benefit period routine. Sure, that is a new illness, but a benefit period depends on how long the patient has been out of an institution, not on the condition he is being treated for. Go back to Item 66 and try again.

ITEM 70 There is an additional deductible equal to the cost of the first three pints of blood furnished a hospital inpatient during his benefit period. The hospital or SNF cannot charge the patient for the blood deductible if he arranges to have the three pints replaced. Although a hospital or SNF can charge the patient its customary charge for blood, the amount charged will be deducted from any payments made to the hospital under the Hospital Insurance program. The patient is obligated for this difference in amounts. (The definition of blood includes whole blood and packed red blood cells. One unit of packed blood cells is equivalent to a pint of whole blood.) The intent of this provision is to encourage the voluntary blood replacement program.

Eric David qualifies for inpatient hospital benefits. During his first stay in a hospital after becoming entitled, he is furnished six pints of blood which cost the hospital \$30 each. The hospital usually charges its inpatients \$50 for each pint of blood. Eric did not arrange to replace any of the blood.

Which of the following is true?

- a. If the hospital charges Eric \$50 per pint for the blood he must pay for himself, \$90 will be deducted from the amount that Hospital Insurance would otherwise pay to the hospital for Eric's inpatient services. (See Item 71)
- b. Since the hospital cannot make a profit on the blood for which it charges a patient, Eric will only have to pay \$90 for the blood furnished to him. (See Item 72)
- c. Eric will have to pay an additional \$60 deductible to cover the cost of the first three pints of blood he is furnished. (See Item 73)

ITEM 71 (70a) This is true. Any amount charged a patient for unreplaced deductible blood is deducted from the amount of other benefits that would be paid to the hospital for inpatient services. A similar provision applies to blood provided by physicians outside the hospital environment. This will be discussed in detail in the text on SMIB. Go on to Item 74.

ITEM 72 (70b) You believe that Eric will only have to pay \$45 for the blood furnished him. This will not necessarily be true, however. The hospital can charge Eric up to its customary charge for his first three pints. But the amount of the charge will be deducted from any benefits that are otherwise payable to the hospital by the intermediary for Eric's inpatient services.

Please return to Item 70 and choose another answer.

ITEM 73 (70c) While it is true that Eric will have to pay an additional deductible for the first three pints of blood furnished him during a spell of illness, this is not a fixed dollar amount. Eric will have to pay up to the amount the hospital's customary charges for the first three pints of unreplaced deductible blood in a benefit period.

Please return to Item 70 and choose another answer.

ITEM 74 So far, we have provided you with the general rules for determining when benefits will be paid under the Hospital Insurance program. Now we will discuss a few of the noteworthy exceptions. As you remember, we said that benefits could only be paid for services rendered by participating hospitals. Payments can also be made for emergency inpatient hospital services or outpatient hospital services rendered by a nonparticipating hospital, if the hospital agrees not to charge the patient for the same covered services, and is the most accessible hospital equipped and available to provide emergency treatment.

In the event the nonparticipating hospital chooses not to accept Medicare payments for emergency services, the patient may request reimbursement subject to the inpatient hospital deductible. The patient receives 60% of the hospital's reasonable charge for routine services and 80% of the reasonable charge for ancillary services. (Ancillary services include X-rays, administration of anesthesia, use of the operating room, etc.) However, if the hospital involved is an all inclusive rate facility, then reimbursement is 66 2/3% of the reasonable charge.

(A special provision for coverage of inpatient hospital services at foreign hospitals is provided if: the eligible person is a resident of the United States, and such foreign hospital was closer to the individual's residence than a U.S. hospital; or emergency services were required by a beneficiary in the U.S. or traveling between Alaska and another State, and the hospital is closer to or more accessible to the place the emergency occurred.)

Beneficiary Steve Foley is involved in an automobile accident and must be taken to the nearest hospital for emergency treatment. The hospital is not a participating hospital.

Assuming that this hospitalization begins a new benefit period, benefits could be paid for the cost, in excess of the \$84 deductible, of the emergency inpatient hospital services that Steve receives if.....

- a. The hospital agrees not to charge Steve for covered services and is the most accessible hospital to the scene of the accident. (See Item 75)
- b. The hospital had an agreement with the Secretary of Health, Education, and Welfare to furnish only emergency services. (See Item 76)

ITEM 75 (74a) Excellent! Emergency hospital services can be covered at nonparticipating hospitals as long as the hospital agrees not to charge the patient for the same covered services and is the most accessible. Steve's hospital did meet the other requirements. Now go on to Item 77.

ITEM 76 (74b) You believe that the hospital must have an agreement to furnish only emergency services. Actually, there is no requirement for such an agreement. In some cases, payments will undoubtedly be made to strictly emergency hospitals. However, the main intent of this provision is to allow emergency services rendered by nonparticipating hospitals to be covered. Please return to Item 74 and choose another answer.

ITEM 77 Inpatient hospital benefits will be paid for services received at Christian Science sanatoriums. These sanatoriums must be operated, or listed and certified, by the First Church of Christ Scientist in Boston, Massachusetts. Only the services which these sanatoriums would ordinarily provide their inpatients will be paid for.

In addition to the regular provisions for inpatient hospital care, the services rendered in a Christian Science sanatorium can be covered as skilled nursing facility services for an additional 30 days. Therefore, a patient after paying the \$84 deductible, could receive up to 60 days of full coverage, 30 days at the \$21 daily coinsurance rate, and 60 days of lifetime reserve at the \$42 coinsurance rate, plus 30 additional days at the \$10.50 daily SNF coinsurance rate. Thus, a total of 180 days is provided for Christian Science sanatorium inpatients. The regular 100 days of SNF services does not apply to treatment in Christian Science sanatoriums.

There are special exceptions to these general rules when the patient is treated both in regular medical facilities and in Christian Science sanatoriums. When a question arises on this topic, you should consult appropriate manuals for guidance. Go to Item 78.

ITEM 78 As we have learned already, the Hospital Insurance program will pay benefits for inpatient hospital services at general hospitals, and Christian Science sanatoriums for 90 days in each spell of illness plus 60 days additional lifetime reserve. The same benefits apply to patients of participating tuberculosis hospitals. Patients in a psychiatric hospital for treatment or diagnosis of mental illness, we have learned, are subject to a special "limitation of days" provision if they are in the hospital on the first day of their entitlement.

There is also a 190-day lifetime limit on covered services for inpatients of psychiatric hospitals. Coverage will not be provided at psychiatric hospitals for more than this number of days during the lifetime of any one person. This lifetime limit is not affected by application of the reduction in days provision.

Beneficiary Doris Rhodes has been in and out of private psychiatric hospitals since her husband died and left her a widow with no other kin at age 67. She was hospitalized the last time from January 3, 1973, to April 6, 1973. Before that she had three confinements of 10 days each, all covered by Medicare in different benefit periods. Doris enters the psychiatric hospital again on July 15, 1973, for a 6-month course of treatment. What will be her last date of covered psychiatric services?

- a. September 19, 1973 (See Item 79)
- b. October 13, 1973 (See Item 80)
- c. September 20, 1973 (See Item 81)

ITEM 79 (78a) We caught you on a sleeper play! With the reminder that 1968 was a leap year, go back to your Julian Calendar and refigure the date. Then select the correct answer to Item 78.

ITEM 80 (78b) Sorry about that. She does not have 90 days of psychiatric care still coming to her, because of the 190-day lifetime limitation on services in psychiatric hospitals for the treatment or diagnosis of mental illness. If there were no limitation, your answer would still be wrong, since she has some days left from her lifetime reserve. Return to Item 78, reread the entire item and then select the correct answer.

ITEM 81 (78c) Congratulations! You correctly figured the total days Doris has spent in the psychiatric hospital.\* You then figured that there were 67 days left in the 190-day lifetime limit on covered psychiatric hospitalization.\*\* The crowning touch was your accurate use of the Julian Calendar to determine the last day of coverage.\*\*\* Go on now to Item 82.

\*1/3/73 = Julian date 003; 4/6/73 = 096; 96-3 = 93 days, plus 30 days prior confinement = 123;

\*\* 190 - 123 = 67;

\*\*\*July 15, 1973 = 196 + 67 = 263 = September 20, 1973.

ITEM 82 Just as general hospitals must meet certain requirements in order to be considered participating hospitals, psychiatric hospitals must meet certain conditions to be considered participating psychiatric hospitals.

Go on to Item 83.

ITEM 83 No payment can be made for services furnished by Federal providers (except for emergency services and services furnished by Federal hospitals that serve as community hospitals).

Which choice below contains only hospitals in which ordinary inpatient services cannot be covered? (Emergency services are payable in any of them.)

- a. Tuberculosis hospitals, Federal hospitals (See Item 84)
- b. Federal hospitals, nonparticipating hospitals (See Item 85)
- c. Psychiatric hospitals, participating hospitals (See Item 86)

ITEM 84 (83a) Although inpatient services furnished by Federal hospitals are usually not covered by the Hospital Insurance program, those furnished by tuberculosis hospitals are covered.

Now go back to Item 83 and choose another answer.

ITEM 85 (83b) Right! Benefits cannot be paid for services furnished to inpatients of Federal hospitals or non-participating hospitals. (Now use your mask again to continue with the program.)

ITEM 86 (83c) Hold it! Benefits can be paid for services furnished by participating hospitals and by psychiatric hospitals. The only restriction with respect to psychiatric hospitals would be for benefits furnished to persons who first became entitled to benefits while they are in the hospital or for persons who already have had 190 days of covered services in psychiatric hospitals. Now go back to Item 83 and choose another answer.

<p>We have learned that the Hospital Insurance program provides protection against the cost of covered inpatient _____ services.</p>	<p>hospital</p>
<p>Some of the services covered are:</p> <ol style="list-style-type: none"> <li>1. Room and board in semi-_____ accommodations;</li> <li>2. Routine _____ care; and</li> <li>3. Drugs furnished by the hospital.</li> </ol>	<p>private nursing</p>
<p>Which of the following is not specifically excluded from coverage as inpatient hospital services:</p> <ol style="list-style-type: none"> <li>1. Physicians' services</li> <li>2. Private duty nursing</li> <li>3. Laboratory tests</li> </ol>	<p>3. Laboratory tests</p>
<p>Benefits will be provided for inpatient hospital services for up to _____ days in each benefit period, besides lifetime reserve days. (how many)</p>	<p>90</p>
<p>In addition to the 90 days in each benefit period benefits are provided for inpatient hospital services for a lifetime reserve of _____ days.</p>	<p>60</p>

<p>However, for benefit periods beginning in 1973, the patient must first pay a \$ _____ deductible amount and also must meet a deductible for the cost of the first _____ pints of blood he receives. (how many)</p>	<p>\$84 3</p>
<p>The patient must also pay a daily coinsurance equal to _____ of the inpatient hospital deductible for the (Fraction) last 30 days of the 90-day period.</p>	<p>1/4</p>
<p>This daily coinsurance is \$ _____ per day and the daily coinsurance for the 60 additional lifetime reserve days is \$ _____.</p>	<p>\$21 \$42</p>
<p>A benefit period ends when the patient has not been an inpatient of any hospital or skilled nursing facility for _____ consecutive days. The 60 day period begins with the day of _____.</p>	<p>60 discharge</p>
<p>The Hospital Insurance program also provides coverage for posthospital _____ care services.</p>	<p>extended</p>

Covered services are those ordinarily provided by skilled nursing facilities to their patients. Generally, these will be semi-private room and board, nursing care, physical therapy, and drugs. True or False? _____	True
However, in no case could payment be made for any service, drug, or other item which could not be paid under the Hospital Insurance program if furnished in a _____. hospital	
To be eligible for these benefits, a patient must first have a qualifying stay of at least _____ days in a hospital and be transferred to the skilled nursing facility generally within _____ days of his discharge.	3 14
Services of a skilled nursing facility are covered for up to _____ days in each benefit period.	100
For each day over the first 20 days that a patient received covered services in an extended care facility, he must pay a coinsurance equal to _____ of the inpatient hospital deductible. (Fraction)	1/8

<p>This coinsurance amount is \$ _____.</p>	<p>\$10.50</p>
<p>The maximum number of days for which extended care benefits will be paid in one benefit period is _____.</p>	<p>100</p>
<p>Skilled nursing facilities also have to meet certain requirements to be eligible to participate in the _____ program.</p>	<p>Hospital Insurance</p>
<p>A third type of benefits provided under the Hospital Insurance program is for posthospital _____ health services.</p>	<p>home</p>
<p>Under this provision, payments would be made for up to _____ visits of home health agency personnel. (how many)</p>	<p>100</p>

Payments under Part A are limited, however, to the _____ year period following the patient's latest discharge from a qualifying stay in a hospital or skilled nursing facility, or until the beginning of a new benefit period, whichever is earlier.	one
To be eligible for Part A home health benefits, the patient would have to have been an inpatient in a hospital for at least _____ consecutive days, or ...	3
have had a covered stay in a _____ facility.	skilled nursing
The home health services plan would also have to be developed and supervised by a _____.	physician
And plans would have to be reduced to writing within _____ days of the patient's discharge from the hospital or skilled nursing facility.	14

<p>Benefits are paid for services furnished in a patient's home on a visiting basis by a participating home _____.</p>	<p>health agency</p>
<p>These services may include:</p> <ol style="list-style-type: none"> <li>1. _____ - time nursing care;</li> <li>2. Some rehabilitative _____; and</li> <li>3. Medical social services.</li> </ol>	<p>part therapy</p>
<p>Specifically excluded from coverage under this provision are:</p> <ol style="list-style-type: none"> <li>1. _____ and biologicals which can be self-administered.</li> <li>2. Physicians' care; and</li> <li>3. Non-_____ related items.</li> </ol>	<p>Drugs  health</p>
<p>Inpatient services at Christian Science sanatoriums will be provided for a total of _____ days in each spell of illness plus _____ lifetime reserve days. (how many) (how many)</p>	<p>120 60</p>
<p>30 days of this period are covered as _____ services.</p>	<p>extended care</p>

For these 30 days, the patient must pay a coinsurance amount of \$ _____ per day.	\$10.50
Benefit payment for inpatient psychiatric hospital services will be made for most services that psychiatric hospitals furnish their inpatients, with the exception of _____ care.	custodial
If a patient is in a psychiatric hospital on the first day he is entitled to benefits, the days he has been in the hospital during the 150 days immediately preceding that day _____ count against the 90-day limit on coverage in that benefit period and also against the 60-day lifetime reserve days, that is, coverage of inpatient psychiatric hospital services.	would (would, would not)
There is a _____ day lifetime limit on coverage of inpatient psychiatric care.	190
Any days subtracted from the 90-day and 60-day limits in the first benefit period of a psychiatric hospital inpatient _____ also be subtracted from his 190-day lifetime.	will not (will, will not)

<p>Psychiatric hospital inpatients are, of course, subject to the \$ _____ deductible for each benefit period.</p>	<p>\$84</p>
<p>and the \$ _____ daily coinsurance for the last 30 days of the 90-day period:</p>	<p>\$21</p>
<p>plus the \$ _____ daily coinsurance for any of the 60 lifetime reserve days used.</p>	<p>\$42</p>
<p>Payments cannot be made for services furnished by a Federal hospital, except for necessary _____ services, or unless the Federal hospital serves as a _____ hospital.</p>	<p>emergency community</p>
<p>Now go to the next page, read the material presented, select one of the given answers, and turn to the ITEM corresponding to the answer you select. You do not have to use the mask for a while now.</p>	

ITEM 1 Up to this point in our lesson we have been saying "patients will receive benefits..." and "persons receiving benefits for covered services..." and so on. Actually, however, the beneficiary will only receive benefits in the sense that he will benefit under the HI program. Benefit payments for covered services will be made directly to the providers of services. Providers of services, of course, are hospitals, skilled nursing facilities, and home health agencies. (For purposes of outpatient physical therapy and speech pathology services, a provider of services is also a clinic, rehabilitation agency, or public health agency.)

Irene Sloan received covered inpatient services from General Hospital. Medicare covered the remaining \$385. Irene had to pay the hospital the \$84 deductible for the inpatient services she received.

Which of the following is true?

- a. The \$385 benefit payment will be made to Irene, who is then responsible for turning the money over to the hospital along with her \$84 deductible. (See item 2)
- b. The \$385 benefit payment will be made to General Hospital. (See Item 3)

ITEM 2 (1a) You believe that Irene will receive the \$385 benefit payment for the covered services she receives. However, this is not the case. Individual beneficiaries will not receive any benefit payments under the plan for hospital insurance (except under **certain** conditions, when emergency services are involved and the hospital refuses to bill the program). Instead, the benefit will be made directly to the provider of services. The covered services that Irene received were provided by General Hospital, and General Hospital will receive the benefit payment. Please return to Item 1 and choose another answer.

ITEM 3 (1b) Right you are! General Hospital was the provider of services, and benefit payments for inpatient services are made to providers of services. Go on to Item 4.

ITEM 4 As you remember, each of the different kinds of providers of services--hospitals, skilled nursing facilities, and home health agencies--have to meet certain requirements pertaining to their purpose, organization and operations in order to be eligible to participate in the HI program. One requirement is that no provider of services can discriminate because of race, color or national origin. This requirement comes from Title VI of the Civil Rights Act of 1964 and will be referred to from here on as Title VI. It seeks to ensure that all beneficiaries will have access to, will not be denied benefits of, and will not be treated differently or separately in any facility because of discrimination. The Public Health Service has been assigned the responsibility for determining whether providers are in compliance with Title VI. The district offices will serve as information channels to route complaints of discrimination against providers directly to PHS. The district office will not be involved in a decision as to whether or not the complaint is justified.

A social security beneficiary calls at the district office. He tells you that he was refused admission to a local participating hospital. He feels very strongly that this refusal was due to his national origin. The correct action to take would be to:

- a. Ask the district manager to contact the hospital, explain Title VI and attempt to resolve the complaint. (See Item 5)
- b. Tell the claimant that hospitals are private institutions and as such they can admit or refuse admittance as they see fit. (See Item 6)
- c. Tell the claimant that his complaint will be passed on to PHS, and make no attempt to resolve the complaint. (See Item 7)

ITEM 5 (4a) The district manager should contact the hospital? Be careful, remember that the district office is not to become involved in resolving the issue, PHS has responsibility for determining compliance. Please return to Item 4 and choose another answer.

- ITEM 6 (4b) The hospital may or may not be a private institution, but the participation in the health benefits program requires compliance with Title VI. Since Title VI bars discrimination, can't something be done? Please return to Item 4 and choose another answer.
- ITEM 7 (4c) Right! PHS has the responsibility for determining compliance with the district office serving as the channel for routing the complaint.
- ITEM 8 The decision as to whether or not to file a complaint is the responsibility of the claimant. PHS will determine compliance. The interviewer in the district office, however, should furnish any program information that might help clear up misunderstandings regarding what benefits are provided under medicare.

A claimant called at the district office and stated that City Hospital told him he would have to pay his surgeon's fee. He believes this is discrimination because of his race. The district office should:

- a. Record the complaint and tell him that he will be advised of the outcome by PHS. (See Item 9)
- b. Explain that surgeon's fees are not covered under the HI program and, therefore, he should not file a complaint. (See Item 10)
- c. Explain that surgeon's fees are not covered under the HI program, but leave it to him as to whether or not he wishes to file a complaint. (See Item 11)

- ITEM 9 (8a) While it is true that PHS will acknowledge receipt and, after investigation, advise the claimant of the outcome, an explanation of types of benefits covered may be needed here. Please return to Item 8 and choose another answer.
- ITEM 10 (8b) You're partly right. The explanation is correct, but we cannot tell a claimant that he should not file a complaint. Return to Item 8 and choose another answer.
- ITEM 11 (8c) Correct. Surgeon's fees are not covered under Hospital Insurance and the claimant should be so advised, but the decision as to whether or not to file a complaint should be left to the claimant.
- ITEM 12 If the claimant decides to file a complaint, the interviewer should assist him in preparing the guide sheet for receiving complaint of discrimination and advise him of the procedure and tell him that further contact should be with PHS.

The complaint may be filed by the individual or through a representative, and if the individual is reluctant to reveal his identity, an anonymous complaint will be accepted. He may deal directly with PHS. In any case, the confidentiality of the information must be safeguarded.

The claimant tells the interviewer that he has been discriminated against by a local hospital in the type of accommodations they gave him, but he is afraid to file a complaint because he may be treated worse if he goes back to the hospital. He should be told:

- a. That he may file a signed complaint either through the district office or directly with PHS, but his name will be kept confidential. (See Item 13)
- b. That he may file a complaint either through the district office or directly with PHS either with or without his name. If used, his name will be kept confidential. (See Item 14).

ITEM 13 (12a) Remember the complaint need not be signed.  
Return to Item 12 and choose another answer.

ITEM 14 (12b) Right! All points are covered here; filed with either the district office or with PHS direct and may be signed or anonymous. The confidentiality of the complaint must be safeguarded.

ITEM 15 Each provider of services must file an agreement with the Secretary of Health, Education, and Welfare not to charge beneficiaries for covered services, and to make adequate provision for refund or erroneous charges. Providers of services would still charge each individual the deductible amounts including any coinsurance amount and for any non-covered services furnished at the patient's request.

Hill Top Nursing Home has been determined to meet all requirements as a skilled nursing facility. Hill Top has also filed its agreement not to charge beneficiaries for covered services and to make adequate provision for refund of erroneous charges. Thus Hill Top Nursing Home is eligible to participate in the Hospital Insurance program and receive benefit payments for covered services provided to beneficiaries. Which of the following statements is true?

- a. Hill Top is qualified and eligible to participate in the HI program. (See Item 16)
- b. Hill Top Nursing Home is not a provider of services, and benefit payments can only be made to providers of services. (See Item 17)

ITEM 16 (15a) Excellent! Hill Top Nursing Home has met all the requirements for participation in the Hospital Insurance program and is eligible to receive benefit payments for covered services provided to beneficiaries. Go on to Item 18.

ITEM 17 (15b) You say "Hill Top Nursing Home is not a provider of services." Why not? Qualified hospitals, skilled nursing facilities and home health agencies are providers of services under the basic plan, and Hill Top is a qualified skilled nursing facility. Please return to Item 15 and choose another answer

ITEM 18 East County Hospital is also fully eligible to receive benefit payments for covered services. Beneficiary Rita Krebs spent one week as an inpatient in East County during January 1974. The cost of her stay (excluding physicians' charges) is outlined below. January 9 began a new benefit period.

January 9 Rita enters hospital

Private room (at her request) and board\*.....\$90/day  
Drugs prescribed by doctor.....\$50 (total)  
Television rental.....\$1/day

January 16 Rita leaves hospital

\*East County Hospital charges \$80/day for semi-private room and board.

How much will Rita have to pay East County Hospital as her share of the cost for her 7-day stay?

- a. \$84 (See Item 19)
- b. \$77 (See Item 20)
- c. \$161 (See Item 21)
- d. \$687 (See Item 22)

- ITEM 19 (18a) Your answer is \$84. This amount is the inpatient services deductible which a hospital can charge beneficiaries for each benefit period and which is applied to the first 60 days of that benefit period. However, hospitals can also charge beneficiaries for any extra services that are not covered by the Hospital Insurance program. Since Rita did receive non-covered services, return to Item 18 and choose another answer.
- ITEM 20 (18b) \$77 is the cost of extra services not covered by the Hospital Insurance program. However, hospitals can also charge beneficiaries the deductible for covered inpatient services. Please return to Item 18 and choose another answer.
- ITEM 21 (18c) \$161.00 is correct. Rita would have to pay the first \$84 plus the difference in charges between a semi-private and private room. The cost of the private room would be covered only if it was medically necessary. She would also have to pay the charge for the television rental since this is a personal convenience and consequently not covered. Go on to Item 23.
- ITEM 22 (18d) \$687 is the total cost of Rita's hospital stay, but participating hospitals cannot, by virtue of their agreement with the Secretary of Health, Education, and Welfare, charge beneficiaries for covered services. Since part of the \$687 total cost is for covered services, the hospital can only charge Rita a lesser amount. Please return to Item 18 and choose another answer.

ITEM 23 Nearly all providers of services receive their benefit payments from fiscal intermediaries. In most instances, a group or association of providers of services will nominate an agency or organization to act as fiscal intermediary for the members of the group or association. The intermediary may be any national, State, or other public or private organization or agency.

If the Secretary of DHEW finds that the nominated organization is qualified, he enters into an agreement with the organization to facilitate benefit payments to member providers of the nominating group or association. A member provider acting alone may not nominate any intermediary. But, a member provider does not need to deal with a fiscal intermediary nominated by its association. In such a case, the provider may request that it deal with any other fiscal intermediary with which the Secretary has already signed an agreement, or it may deal directly with the Federal Government. The latter course does not afford any financial advantages, however.

Providers that do not belong to any group or association are also restricted to dealing with a fiscal intermediary already nominated by some association. This limitation reduces the number of fiscal intermediaries with which SSA has to deal, and limits the selection of fiscal intermediaries to organizations which have already been found acceptable by DHEW.

Blue Cross has been nominated to act as fiscal intermediary for the members of North District Hospital Association. Hillside Hospital is a member of NDHA. Therefore:

- a. Blue Cross will arrange to have the Social Security Administration pay for the cost of services under the HI program directly to the Hillside Hospital. (See Item 24.)
- b. Blue Cross will be a fiscal intermediary if it enters into an agreement with the Secretary of DHEW and pays for the cost of covered services to the Hillside Hospital. (See Item 25.)

- ITEM 24 (23a) The term fiscal intermediary implies that the transactions between the Secretary and the providers of services will be handled by a third party. These transactions include the payment for services. Please return to Item 23 and select another answer.
- ITEM 25 (23b) Your answer is correct. The provider of services (in this case the Hillside Hospital) will be paid directly by the fiscal intermediary (Blue Cross) since Blue Cross has been nominated as the fiscal intermediary and will enter into an agreement with the Secretary of the DHEW. Now go on to Item 26.

ITEM 26 These agreements or contracts with the Secretary provide for the fiscal intermediary to determine what amount of benefits should be paid to providers of services, and to make the benefit payment to the providers. The intermediary is then reimbursed by the Federal Government.

This contract may also provide for the fiscal intermediary to perform any or all of the following functions:

- (1) provide consultative services to hospitals, skilled nursing facilities, and home health agencies to enable them to establish and maintain fiscal records necessary for participation in the HI program;
- (2) serve as a channel of communication between the provider of services and the Secretary, and vice versa;
- (3) make such audits of the records of the providers as necessary to insure proper payment of benefits; and
- (4) assist providers of services in providing safeguards against the unnecessary utilization of services.

Continental Casualty Company has been nominated to be an intermediary by Central Hospital Association. Mercy Hospital is a member of Central Hospital Association. If Continental Casualty Company enters into a contract with the Secretary of DHEW as a fiscal intermediary which of the following statements is correct?

- a. The local social security office will have its field representatives audit the hospital bills to see that the hospital is not overcharging Continental Casualty. (See Item 27)
- b. Continental Casualty will serve as a channel of communication between Mercy Hospital and the Secretary of DHEW. (See Item 28)
- c. Continental Casualty will determine what amount of benefits will be paid to Mercy Hospital, and will make benefit payment to Mercy Hospital. (See Item 29)

ITEM 27 (26a) Although the law does not specifically exclude an arrangement such as this, at present there is no likelihood that the district office will be involved in an audit function. In most cases the Secretary will provide for the fiscal intermediaries to audit the records of participating hospitals. This function would be included in the contract between the Secretary and the fiscal intermediary. Since, in our example, we have not specified the terms of the agreement between the Secretary and Continental Casualty Company, it is not possible to say for certain where the responsibility for audit of Mercy Hospital's records lies. Now return to Item 26 and choose another answer.

ITEM 28 (26b) In most instances this function will probably be included in the contract between the Secretary and the fiscal intermediary. However, it is not a necessary part of the contract. Since in our example, we have not specified the terms of the contract between the Secretary and Continental Casualty, you cannot determine that this statement is correct without further information. Please return to Item 26 and choose another answer.

ITEM 29 (26c) Very good! Under the agreement with the Secretary of DHEW, a fiscal intermediary such as Continental Casualty (in this case) agrees to determine what amount of benefits should be paid to providers of services and makes the payments to the providers.

ITEM 30 In determining the amount of benefit payments to be made to a provider of services, the fiscal intermediary bases reimbursement on a "reasonable cost" concept. The Regulations establish guidelines for determining the reasonable cost of covered services. In arriving at the reasonable cost of services, most cost items (cost to the provider), such as depreciation, cost of equipment, supplies, and labor, are taken into consideration. Excluded as cost items would be costs of operating gift shops in the hospital, financing building drives, and conducting pure research. Reimbursement to the hospital of providing bed and board is based on reasonable cost of semi-private accommodations.

Of the following, select the group of expenses that can all be considered cost items in arriving at reasonable costs.

- a. Light, heat, cost of food, depreciation, office salaries, and salary of interns. (See Item 31)
- b. Nurses' salaries, cost of an X-ray machine, lunches for workers on the building drive, and elevator maintenance. (See Item 32)

- ITEM 31 (30a) The answer is correct. All of the cost items mentioned, such as light, heat, cost of supplies, depreciation, office salaries, and salaries of interns, are operating expenses that are taken into consideration in computing reasonable cost. Now go on to Item 33.
- ITEM 32 (30b) Certain salaries such as nurses' salaries and the cost of equipment such as the X-ray machine and the maintenance costs for elevators and operating costs that are considered when arriving at a reasonable cost for bed and board. Lunches for workers on a building drive, however, or any other expenses connected with the raising of money for a hospital are not expenses that can be used in computing reasonable cost. Please return to Item 30 and select another answer.
- ITEM 33 As you have already learned, the inpatient hospital services deductible is \$84. This deductible will remain \$84 until at least December 31, 1974. For benefit periods beginning in 1975 and each succeeding calendar year thereafter, revised deductible rates will be determined by the Secretary during the period of July 1 - October 1 of the preceding year, based on changes in the cost of hospital services.

Now let us check your understanding:

- a. The inpatient deductible may be increased at any time after January 1, 1975, by the Secretary if increased hospital costs warrant an increase. The Secretary's decision must be published in the Federal Register. (See Item 34)
- b. The inpatient deductible may be revised for benefit periods beginning on or after January 1, 1975, based on changes in the cost of hospital services. The determination will be made between July 1 and October 1 of the previous year. (See Item 35)

ITEM 34 (33a) Did we say that? There is a definite limit on the time a deductible change can be made. At any rate, we said nothing about the Federal Register although that was a good guess. Now return to Item 33 and choose another response.

ITEM 35 (33b) The answer is correct. All deductible changes will be effective on January 1 of the particular year, and the decision must be made and published during the third quarter of the preceding year. This gives the public a few months advance notice on such changes.

ITEM 36 The effective date for benefits under the HI program was July 1, 1966, for in-hospital services and home health services. However, for posthospital extended care services, the effective date for coverage was January 1, 1967. In no event were benefits payable before these effective dates. Like all other types of RSDI claims there is a 12-month retroactive period for entitlement to Hospital Insurance benefits. However, unlike other RSDI benefits, benefits under the HI program terminate with the month of death and not with the month before the month of death.

Clara Jones was in the hospital during the months of July and August 1973. She died while in the hospital on August 17, 1973. After the deductible has been taken care of:

- a. The hospital will be paid for covered services under the HI program for the month of July only. (See Item 37)
- b. Clara's estate will also have to pay for the cost of drugs used during her treatment but will not have to pay for any other services through the date of death. (See Item 38)
- c. All covered services for the months of July and August, up to and ending with the date of death, will be paid for under the HI program. (See Item 39)

- ITEM 37 (36a) The hospital will be paid for covered services provided during July, of course. However, benefit payments under the Hospital Insurance program do not terminate with the month before the month of death as do RSDI benefits. Under the Hospital Insurance program services are covered up through the date of the patient's death. Please return to Item 36 and choose another answer.
- ITEM 38 (36b) Just a moment now. The Hospital Insurance program covers all ordinary hospital services, including drugs. Benefit payments are made for all covered services as long as the beneficiary remains entitled to them. Please return to Item 36 and choose another answer.
- ITEM 39 (36c) Your answer is correct. All covered services for the months of July and August, up through August 17, the date of death, will be paid for under the Hospital Insurance program. Unlike other social security benefits, benefits under the Hospital Insurance program terminate with the month of death and not with the month before the month of death. Go to Item 40.

ITEM 40

The physician has a very important part in the administration of the Hospital Insurance program. He must approve the admission of a patient to a hospital, order tests, drugs, and treatments, and determine the length of stay. For this reason, payment of benefits can be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time, recertification by the physician is necessary. Written certification of medical necessity is waived for general hospital admissions and for outpatient services in recognition of the fact that admission or rendering of outpatient services in itself ordinarily attests to medical need.

The Federal Government, of course, has no authority to supervise or control the practice of medicine. This means that the patient will retain complete freedom of choice in the selection of a personal physician.

Beneficiary Bill Foss has heard from some of his friends that Medicare is really socialized medicine. He is concerned about his free choice of doctor and "Government running the practice of medicine." What would you tell Mr. Foss in order to clarify his impressions?

- a. The Federal Government will not interfere with the ordinary practice of medicine by physicians outside of hospitals, but will set up standards and regulations for their practice in participating hospitals. (See Item 41)
- b. Individuals will still be able to select their own doctor. Government physicians will only be used to certify as to the necessity of covered services. (See Item 42)
- c. A beneficiary's personal physician will not in any way be under Government supervision or control. He must cooperate with certain certification procedures, however, if benefits are to be paid for covered services. (See Item 43)

ITEM 41 (40a) This is not true. The Federal Government will not interfere with the practice of medicine by physicians outside the hospitals or inside the hospitals. Nor will the Government interfere with the administration of hospitals or other medical facilities.  
Please return to Item 40 and choose another answer.

ITEM 42 (40b) You may be somewhat confused here. Individuals will be able to select their own doctor. The Government will not interfere with the practice of medicine. Although a physician will have to recertify to the medical necessity of covered services, in longterm illnesses, the doctor involved will usually be the patient's private physician. These physicians will not be working for the Federal Government.  
Please return to Item 40 and choose another answer.

ITEM 43 (40c) You are right again. The Federal Government will not have any control over the practice of medicine or the selection of a personal physician. However, in order for benefit payments to be made under the basic plan, the beneficiary's physician must recertify periodically that the covered services are medically necessary where services are furnished over a long period of time. (Remember, we assume medical necessity at the time of initial admission to a general hospital.) In the case of inpatient hospital services for which payment would be made, the physician would have to recertify that the services were required for the individual's medical treatment as of the 12th day after admission, as of the 18th day, and again no later than every 30 days. Certification on admission is required in certain instances.

ITEM 44 In the case of posthospital extended care services a physician would have to certify that the patient needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which he received inpatient hospital services, and which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. And for home health services he would have to certify that the individual was confined to his home, and needed home health services for treatment of a condition for which he has received inpatient hospital services or post-hospital extended care.

In the case of inpatient psychiatric hospital services, a physician would have to certify that the psychiatric services could reasonably be expected to improve the patient's condition or were for medically necessary diagnostic study. The intent here is to provide assurance that only active treatment and not custodial-type care is being paid for under the Hospital Insurance program.

Finally, for the same reason, tuberculosis hospital services could be covered only where the physician certified that the treatment could reasonably be expected to either improve the condition for which the treatment was necessary or render the condition noncommunicable.

(CONTINUED ON NEXT PAGE)

Which of the following statement is true?

- a. Benefit payments cannot be made for extended care services unless the attending physician certifies that the patient needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which he received inpatient hospital services, which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. (See Item 45)
- b. Benefit payments for only certain services can be made without a physician's certification or assumed certification, as to their medical necessity. (See Item 46)
- c. Tuberculosis hospital services cannot be covered unless the treatment is expected to completely cure the patient. (See Item 47)

ITEM 45 (44a) Excellent! A physician's certification as to the medical necessity of extended care services is always required before benefit payments can be made. Extend care services can be covered only if they are for the continued treatment of a condition for which the individual had received inpatient hospital services for the care of a condition which arose after the individual was transferred to the skilled nursing facility but while he was still being treated for a condition for which he had received inpatient hospital services.

In addition to a physician's certification, before any payment can be made the patient must sign a written request for payment at the hospital. If it would be impracticable for the patient to sign the request when admitted, e.g., he is unconscious, incompetent, or in great pain, another person can sign for him. This could be a representative payee, friend, relative, or welfare worker. The request is then filed with the intermediary or SSA if the hospital deals directly with the Government. If there are multiple admissions during one benefit period a request is required for each inpatient hospital admission. Go on to Item 48.

ITEM 46 (44b) You didn't really mean that, did you? Benefit payments cannot be made for any services without a physician's certification as to their medical necessity. Medical necessity is assumed when a physician admits a patient to a general hospital or when outpatient services are rendered. Please return to Item 44 and choose another answer.

ITEM 47 (44c) Although tuberculosis hospital services can be covered if the physician certifies that the patient can reasonably be expected to be cured, they can also be covered if he feels (1) the condition will be improved, or (2) rendered noncommunicable. Now return to Item 44 and choose another answer.

ITEM 48 If the individual is dissatisfied with any determination about the coverage under Medicare of services he was furnished by a provider, he is entitled to a reconsideration by the fiscal intermediary. Patients protesting whether the health insurance program should assume liability for services furnished will be referred to the district office by the hospital. If, after a reconsideration, the individual is still dissatisfied, and the amount in question is \$100 or more, he may request a hearing. If he then is still dissatisfied, he may request a review by the Appeals Council of the Bureau of Hearings and Appeals and, finally, if the amount in controversy is \$1,000 or more he may request a court review.

When Frank Henry received his bill from City Hospital, it showed that he owed \$125 for his private room. He believes this is wrong because his doctor suggested the private room and complains to the hospital. The correct hospital procedure is:

- a. For the hospital to have him contact the fiscal intermediary who will make the decision. (See Item 49)
- b. For the hospital to refer him to the district office for assistance in filing a request for reconsideration, which will be the final level of appeal in this case. (See Item 50)
- c. For the hospital to refer him to the district office. He can have a reconsideration and if still not satisfied, a hearing. (See Item 51)

- ITEM 49 (48a) No. Remember we said that he can receive a reconsideration determination which the fiscal intermediary and that the hospital should refer an individual to the district office. Return to Item 48 and select another answer.
- ITEM 50 (48b) Close, but this won't necessarily be the final level of appeal. Since the amount in question is over \$100 a hearing can be granted if the individual is still dissatisfied after receiving the reconsidered determination. Return to Item 48 and select another answer.
- ITEM 51 (48c) Right. He is entitled to a reconsideration and since over \$100 is in question, Frank would also have right to a hearing. Now go on to the next page. You will have to use the mask for a while.

<p>Let us review what we have learned in this section.</p> <p>Payments for covered services are made to the _____ of services. (i.e., hospitals, skilled nursing facilities or home health agencies).</p>	provider
<p>To receive payment a provider of services must agree not to charge beneficiaries for covered services and to make provision for refund of erroneous charges. True or False? _____.</p>	True
<p>Benefits will be paid to participating providers of services by fiscal _____.</p>	intermediaries
<p>A fiscal intermediary can be any national, State, or other public agency selected by a group or association of providers of _____.</p>	services
<p>The Secretary enters into agreements with selected fiscal intermediaries to pay providers of services for the services covered under the basic plan on a " _____ " basis.</p>	reasonable cost

<p>Among other things, the fiscal intermediary will: (Select one)</p> <p>a. Make determinations as to eligibility for benefits.</p> <p>b. <del>Serve as a channel of communication between the provider of services and the Secretary, and vice-versa</del></p>	<p>b</p>
<p>The fiscal intermediary will not however: (Select one)</p> <p>a. Make audits of the records of the providers to insure proper payment.</p> <p>b. Assist providers in providing safeguards against unnecessary utilization of services.</p> <p>c. Determine what treatment the doctor should prescribe for a beneficiary</p>	<p>c</p>
<p>In arriving at "reasonable costs" the cost to a hospital of providing bed and board will be the cost of _____ - _____ accommodations.</p>	<p>semi-private</p>
<p>In arriving at reasonable costs which of the following cannot be included?</p> <p>a. depreciation of buildings</p> <p>b. cost of repair to existing facilities</p> <p>c. light and heat</p> <p>d. salaries of nurses and aides</p> <p>e. the cost of gift shop operation</p> <p>f. cost of a new X-ray machine</p>	<p>e. the cost of gift shop operation.</p>
<p>We have also learned that the \$84 deductible for inpatient hospital care will be \$84 at least until _____.</p>	<p>January 1, 1975</p>

For benefit periods beginning in 1975 and each succeeding calendar year, the deductible amount will be determined by the Secretary between July 1 and October 1 of the <u>previous</u> year. True or False?	True
In addition we learned that like all other types of OASDI benefits there is a <u>          </u> month retroactive period for (how many) entitlement to Hospital Insurance benefits.	12
However, benefits will not be paid for the month of death. True or False?	False. Benefits under the HI program may be paid for the month of death.
Another point covered was that payment of benefits could only be made if the medical necessity of the services is certified by the beneficiary's <u>                                </u> . (Medical necessity is assumed in certain cases.)	physician, doctor, etc.
We also learned that the patient <u>                    </u> select (can, cannot) his own doctor...	can

and that the Government has no authority to supervise or control the practice of _____.	medicine
In the case of admission for inpatient hospital services in a general hospital, a physician's written certification that the services were necessary for the individual's medical treatment is not required because the medical necessity can be assumed from the fact of admission. True or False? _____.	True
In cases of posthospital extended care, a physician would have to certify that the care was required because of need for skilled nursing care on a continuing basis for <u>any</u> condition. True or False? _____.	False. Care must be for the same condition for which he had received inpatient hospital care.
And in cases of home health services, he would have to certify that the beneficiary was confined to his home and needed the home health services for treatment of a condition for which he had received inpatient hospital services or covered posthospital _____.	extended care
With respect to psychiatric hospitals, the physician must certify in writing that the treatment could reasonably be expected to improve the condition or was for medically necessary diagnosis. This distinguishes active treatment (covered) from purely _____ care (not covered).	custodial

Before any payment can be made, the patient or his representative must sign a request for _____.	payment
Another person may sign for the patient if it is impracticable for him to do so. True or False?_____.	True
Requests for reconsiderations involving whether payment of expenses are covered by the Hospital Insurance program _____ be handled by the district (may, may not) office, which in turn forwards the request to the servicing intermediary.	may
The amount in question must be \$ _____ or more before a hearing can be granted, while the amount must be \$ _____ or more before a court review may be requested.	\$100 \$1,000

## INSTRUCTIONS FOR USING JULIAN DATE CALENDARS

1. "BENEFIT PERIOD." Find Julian date for day of discharge--Add 60--The sum is the Julian date for the first day the next benefit period can begin. Admission to a hospital or SNF before this day will extend the current benefit period.
  
2. DAYS OF HOSPITAL CARE. Find Julian date for day of discharge. Subtract the Julian Date for day of admission. Remainder is the number of days of hospital care [unless discharge was after scheduled discharge time].

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# JULIAN DATE CALENDAR

(PERPETUAL)

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

# JULIAN DATE CALENDAR

FOR LEAP YEARS ONLY

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
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31	031		091		152		213	244		305		366	31

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